Aminya Village Hostel

Performance Report

14 Adelaide Rd
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**Commission ID:** 6136

**Provider name:** Mid Murray Homes for the Aged Inc

**Site Audit date:** 31 May 2022 to 3 June 2022

**Date of Performance Report:** 8 August 2022

# Performance report prepared by

Andrea Hopkinson delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Non-compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 1 July 2022.
* referral information received by the Commission.

# STANDARD 1 COMPLIANTConsumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

Overall sampled consumers considered they were treated with dignity and respect, could maintain their identity, make informed choices about their care and services and live the life they choose. Specific feedback included:

* Consumers reported being supported to make connections with others and maintain relationships of choice.
* Consumers sampled confirmed they were supported to take risks and did not feel restricted in their movements or choice of activity.
* Consumers reported their privacy was respected when staff deliver care and services.

Staff demonstrated knowledge of consumers’ individual identity, culture and diversity and could relay strategies to promote choice and independence. Staff reported they regularly engaged consumers in making informed choices about their care and services through informal conversations in everyday care.

Care plans sampled showed information relating to consumers’ ethnicity, cultural practices, religion and cultural days celebrated. The Assessment Team sighted evidence consumers were supported to exercise choice and independence in relation to their own care and service delivery, communicate their decisions, make connections with others and maintain relationships of choice.

With regards to supporting consumers to take risks, the service demonstrated consumers were able to engage in risk taking activities, such as using electric mobility vehicles, leaving the service unaccompanied, smoking in designated areas and eating certain meals of choice despite associated risks. The Assessment Team however, noted that risk assessments and strategies were not consistently implemented for some consumers. The Approved Provider’s response included further actions that were being completed and I have considered this information in relation the service’s assessment and care delivery along with its overall governance systems.

Observations made by the Assessment Team demonstrated consumers were treated with kindness, respect and dignity by staff and their personal information to be managed confidentiality. Community notice boards on display at the service, showed up to date menus, activities and events with photographs to assist in understanding. Staff described providing information in a variety of formats and supporting consumers who had sensory or cognitive impairments to ensure information provided was effectively communicated and understood.

The service had overarching strategic documents, policies and procedures which described an inclusive and consumer-centred approach to organisational practices and service delivery.

The Quality Standard is assessed as Compliant as six of the six specific requirements have been assessed as Compliant.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

Overall, most consumers and representatives said they felt like partners in the ongoing assessment and planning of their care and services. Feedback included:

* Consumers confirmed they or a person of their choosing, were involved in care planning and had a say in the delivery of care and services.
* Most consumers and representatives said assessments and planning were effectively communicated and readily available if required.
* Most consumers advised staff were aware of their needs and preferences and these were generally met.
* Consumers and representatives confirmed palliative care and end of life wishes were discussed when entering the service and through the care plan review process.

The service generally demonstrated the assessment and planning process was supported by the use of validated risk assessment tools and was used to inform safe and effective care and services. Although the Assessment Team found some deficiencies in the service’s assessment and care planning processes relating to equipment, the completion of behavioral support plans and pressure injuries, I find this information more relevant in relation to Standard 2 Requirement 3(e) and Standard 3 and therefore I have considered this information in respects to these Standards.

Care plans sampled were overall developed from information gathered through consultation with consumers and/or representatives on entry and on an ongoing basis. Most consumer care plans sampled included information relating to consumers’ goals, needs and preferences including end-of-life-wishes as well as the involvement of other organisations and individuals. Although the Assessment Team found some care plans did not reflect specific interventions for consumers, other consumer files showed a current care and services plan which was readily accessible.

Staff advised they had access to consumer care documentation through the service’s electronic system and described how they used the information to provide care. Clinical staff were knowledgeable of how they approached end-of-life and advanced care planning and how consumers and/or representatives were involved in assessment and care planning on entry, at 6 monthly scheduled reviews and when needs or preferences changed.

While the service had policies and procedures to guide practice in relation to assessments and care planning including end of life wishes and care, the Assessment Team recommended one requirement Not met as the service was not able to demonstrate care and services were reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

The Approved Provider provided a written response in relation to above matters and based on the information before me, I find the service Non-compliant in Standard 2 Requirement 3 (e). The reasons for my decision are outlined below under the specific requirement.

The Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

### Requirement 2(3)(b) Compliant

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

### Requirement 2(3)(c) Compliant

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

### Requirement 2(3)(d) Compliant

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

### Requirement 2(3)(e) Non-Compliant

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

The Assessment Team recommended this requirement as Not met. While the Assessment Team noted clinical staff were able to describe processes for the initial, six monthly and ongoing reviews of consumers’ clinical documentation it was not able to demonstrate care and services had been reviewed or evaluated in response to a change for one consumer relating to their emotional and psychological wellbeing. Information and evidence reported by the Assessment Team relevant to my finding included:

* Consumer A had a diagnosis which included dementia, depression, anxiety and other mood related disorders. The consumer’s care plan stated, ‘increasing social withdrawal’. While staff reported providing encouragement to the consumer to come out of their room, join in activities provided and to socialise with other consumers, the Assessment Team reported:
	+ There was limited information to demonstrate that staff had considered if ongoing pain from a fracture or changes in mobility had led to their increasing withdrawal.
	+ There were minimal documented strategies in the consumer’s care plan or behaviour assessment/planning to guide staff as to what emotional and psychological support was to be provided.
	+ There had not been a referral to medical specialists or services including evidence of the medical officer being informed of the consumer’s emotional wellbeing and social withdrawals.
	+ Progress notes did not identify what emotional and psychological support was provided and how effective staff had been in encouraging the consumer to be more social and spend time with other consumers.

The Approved Provider’s response disagreed with the Assessment Team’s findings reporting the service had undertaken appropriate monitoring and assessments of the consumer. In addition, it had providing clarifying information in relation to Consumer A’s diagnosis, involvement of the medical officer and outlined it was a misunderstanding of clinical guidance and provided an extract of their care plan for clinical staff to monitor for increased depression indicators. It reported:

* In addition to pharmacological treatments for this consumer (to treat depression), non-pharmacological interventions were included in the leisure and lifestyle care plan, and records continued encouragement by staff for participation in activities. However, its response noted the consumer will often decline preferring to participate in one to one activities with staff in their room.
* In relation to access to the consumer’s care plan, it reported these was being reviewed prior to the site audit and as consumers do not always recall receiving a copy a sign off box would be implemented into its assessment tool.
* Since the visit, further discussion regarding the consumer’s condition had occurred specifically in relation to their fracture and consideration of options for surgical interventions. The medical officer had also referred the consumer to specialist mental health service for review.

In coming to a view about compliance, I have considered the information in the Assessment Team’s report and the Approved Provider’s response. I acknowledge both the consumer and staff confirmed staff were aware of the consumer’s social isolation and were encouraging their involvement in activities and to engage with other consumers. However, I am not persuaded by the Approved Provider’s response, as it had not adequately demonstrated the strategies being implemented including if these had been recently reviewed or evaluated for their effectiveness. In addition, I note the Approved Provider had reported the consumer would often decline activities, preferring to participate in one to one with staff, but had not outlined whether these alternative strategies were effective. Furthermore, I acknowledge a referral had since been made by the consumer’s medical officer to support a review of the consumer by older persons mental health service and the service reported it continued to undertake formalised wellbeing checks, which had occurred on four occasions during June 2022.

I have also considered the totality of other information reported within the Assessment Team’s report specifically in relation to review of services under Standard 4 and Standard 8 where, the Assessment Team identified further examples of where care or services had not been reviewed regularly for their effectiveness or following incidents. Whilst I note these were reported under other requirements, I note the intent of this requirement extends to review of services not just care for consumers. Specific examples included:

* Overall half (four of seven) lifestyle assessment plans sampled were not reviewed in line with the service’s policy which states they were to be reviewed on a 6-monthly basis. Furthermore, the Assessment Team noted three of seven sampled lifestyle care plans did not, or only partly, contain descriptive information relating to those consumers specific interests and preferences. At the time of the visit, I acknowledge management said they will change the goal to be more tailored and specific upon each consumer’s next lifestyle assessment.
* The Assessment Team viewed serious incident reports from 1 January to 31 May 2022. Of the 10 incidents reported, seven incidents of physical abuse involved related to two consumers. Whilst the Assessment Team noted for one consumer they had been reviewed in February 2022 by a dementia specialist service and strategies implemented, most incidents occurred after February 2022 and at the time of the site audit either consumer had a behaviour support plan with strategies for managing and preventing incidents of physical abuse. The Approved Provider’s response outlined behaviour support plans were now in place for both consumers with consent for the use of the restrictive practice. Both were listed on the high risk register and regular wellbeing checks were being undertaken.
* I also note that whilst the service assessed the consumers for physical injury with nil reported and emotional support and visual safety checks were recorded as having been completed, there was no assessment for possible ongoing psychological injury where five incidents raised showed the consumer initially displayed an emotional response to the incident. Although I acknowledge one of the consumers was no longer residing at the service, at the time of the site audit and I do not have any further information to support there was an ongoing impact on the consumers, I am concerned the service’s response following these incidents which indicated there was no psychological impact, as the consumers had a diagnosis of dementia and they forgot about the incident shortly after it occurred.

Therefore, based on the information before me, I find the service Non-compliant with this requirement as at the time of the visit, the service was not able to demonstrate care and services were regularly reviewed for effectiveness when changes or incidents impacted on the consumer. I acknowledge further actions and improvements were being implemented and the service will require a period of time to demonstrate the effectiveness of its systems.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

Overall most sampled consumers and representatives considered they received quality care and services when they needed them and from people who were knowledgeable, capable and caring.

* Feedback from consumers and representatives indicated they felt comfortable talking to the service staff about their future wishes, with one representative reporting their satisfaction with the care provided during palliation.
* Consumers and representatives sampled are confident staff providing care and services would identify changes to consumers’ health and well-being and will refer them to other allied professions when necessary.
* Consumers and representatives said their needs and preferences were effectively communicated between staff, as most reported they received quality and continuous personal or clinical care.

The organisation had systems in place to generally support the active communication with others both internally and externally. Staff were able to explain how they were informed about a consumer’s needs, goals, and preferences as it related to their own role.

The service was able to demonstrate the needs, goals and preferences of consumers nearing end of life are addressed, their comfort maximised and their dignity preserved. Staff interviewed described and documentation showed discussions are held with consumers and representatives about the provision of palliative care and that it is provided in line with consumers’ wishes. Clinical staff were able to describe end-of-life processes and how information is gathered on entry and reviewed every 6 months or as required if there is a sudden deterioration in the consumer’s condition in discussion with the family. The service has processes in place to guide staff in planning palliative care in partnership with consumers and/or representatives.

The service was generally able to demonstrate the minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection; and practices to promote appropriate antibiotic prescribing and reduce the risk of increasing resistance to antibiotics. Staff could explain how they minimise the risk of infection and describe the practical steps taken to reduce the risk of antibiotic resistance. The service had a documented infection control program, including an outbreak management plan, and the collection of consumer and staff influenza and COVID-19 vaccination status.

However, the service was not able to demonstrate that each consumer received safe and effective personal care or clinical care that was best practice, tailored to their needs and optimised their health and well-being in relation to management of behaviours, fall management, restrictive practice and the assessment of risks associated with use of bed poles/bed rails.

While consumer files viewed demonstrated the service identified some high-impact and high-prevalence risk through assessment processes and documented individualised strategies, clinical risks were not always managed in relation to risks associated with choking and aspiration, prevention and management of pressure injuries and wound care. Furthermore the Assessment Team noted the service did not consistently escalate deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition, and in a timely manner for two consumers.

The Assessment Team recommended three requirements as not met in relation to safe and effective care, management of high impact/high relevance risks and timely escalation of consumers’ deterioration. The Approved Provider provided a written response which included a plan for continuous improvement.

Based on the information before, I find the service Non-compliant in relation to Standard 3 Requirement 3(a) and 3(b). However, I have come to a different view in relation to Standard 3 Requirement 3(d) and find this requirement Compliant. The reasons for my decision are outlined below under the relevant requirements.

The Quality Standard is assessed as Non-compliant as two of the seven specific requirements have been assessed as Non-compliant.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team found that although most sampled consumers and representatives considered they received quality care and services, the service was not able to demonstrate each consumer received safe and effective personal care or clinical care that was best practice, tailored to their needs and optimised their health and well-being. Specifically these related to the management of behaviours, falls management, restrictive practice and the assessment of risks associated with use of bed poles/bed rails. Information and evidence provided by the Assessment Team relevant to my findings included:

* Consumer B recently entered the service:
	+ Progress notes indicated when the consumer displayed changing behaviours, staff did not always try alternative strategies before psychotropic medication was administered.
	+ Following the consumer’s falls, neurological observations were not always completed as per the service’s protocol. The service’s post fall assessment including neurological, and changes in level of consciousness as a result of an unwitnessed fall does not provided information to guide staff as to how often and for how long neurological observations are to be taken.
	+ The medical officer was not notified when the consumer did not eat their breakfast and lunch and was too sleepy to administer medications safely and had to awaken following their fall.
* Dignity of risk forms had not been completed for three consumers (Consumer A, C and D) where equipment such bed rails and poles were implemented.
* Sixteen of 21 consumers who were subjected to a restrictive practice, did not have a behaviour support plan to align with current legislative requirements and staff interviewed were not aware of the requirement for behaviour support plans (BSP).

Although the Approved Provider did not disagree with the Assessment Team’s overall recommendation, its written response did refute aspects of the evidence presented relating to named consumers. Its response included further clarifying information by way of clinical documentation for individual consumers and had submitted a plan for continuous improvement to demonstrate actions being undertaken.

In relation to Consumer B, its response outlined:

* The consumer’s background medical condition and report the consumer had only recently entered the service six days prior to the site audit. It outlined the behaviours were most likely usual for the consumer and progress notes were demonstrating the consumer was displaying restlessness, confusion and some agitation from admission and staff provided considerable emotional and psychological support to gain familiarity with the new environment.
* The consumer had been admitted with pre-existing prescribed psychotropic medications and these were administered as prescribed including PRN following non-pharmacological interventions. Further reviews/consideration of reduction to these medications would be discussed and managed, but at the time the consumer was still transitioning to the new environment.
* Whilst there was a 22 day assessment tool; this would not have been reasonable given the short time at the service to complete and an interim care plan and high-risk assessments were present.
* The restrictive practice consent form and behaviour chart had been generated and with the medical officer for discussion with the consumer’s representative and reported the representative had given verbal consent to use the medications.
* There was an instance of emergency use of a PRN psychotropic medication and considered its response was in line with relevant legislation.
* It clarified the service did have a post fall management clinical pathway and submitted a copy of this.
* In relation to the escalation of concerns to the medical officer due to increased sleepiness and completion of neurological observations, it had advised staff had implemented equipment and place on hourly visual observations and therefore considered it had completed post falls observations and holistically considered the consumer’s clinical needs. It did not consider this warranted urgent escalation and asserted clinical judgement and decision making was used.
* In relation to an impairment for swallowing, the service advised the consumer did not have a diagnosis of dysphagia and experienced two episodes of coughing. A referral had been made and registered staff put in place apparent interventions.
* Since the visit, the consumer has continued to settle, and ongoing consultation has occurred to understand the consumer’s history, background to behaviours and things that were important to them. Furthermore, a speech pathology and hearing review had also since been completed.

In relation to Consumer C, D and A, the Approved Provider reported that a dignity of risk form was not required to be completed. However, the service did have in place a comprehensive information sheet for consumers and representatives of the risks associated with bed rails and bed poles and specific policies and procedures to guide staff in their use. It provided evidence of a restraint assessment and review for Consumer C, which included authorisation and discussion with consumer’s representative regarding the risk associated. It outlined the service practice was to have an assessment, inclusion of a restrictive practice consent and authorisation.

In relation to the implementation of behaviour support plans, the Approved Provider acknowledged these had not been completed. Specifically, it reinforced there was a scheduled implementation and actions were being undertaken to address this.

In coming to a view about compliance, I have considered the Assessment Team’s findings and the Approved Provider’s response. I acknowledge the improvements being implemented in relation to behaviour support plans and further actions being undertaken.

* In relation to the consumers identified by the Assessment Team, I accept the service has a process for the risk assessment of bed rails/poles; policies and procedures and information sheets to outline the risk of their use. I note the service had provided evidence of one consumer’s completed assessments and reported this process was used for other consumers, although it did not evidence this. I further note that the reasoning for use of the bed rails did not consistently align with its policy/information sheet, but note the risk and monitoring were reported to be in place.
* In addition, the Approved Provider’s response outlined under Standard 7, identified one consumer has since had their bed pole removed and the second consumer would have theirs removed as soon as a bed cradle was delivered. However, I note the service’s processes was for a risk assessment form to be completed instead of a dignity of risk form, I note staff did not understand the requirement for risks to be discussed with consumers and representatives.
* Furthermore, in relation to Consumer B, I acknowledge the consumer had only entered the service a few days prior to the site audit and was still transitioning into a new environment. I also accept the service was able to provide evidence of its post clinical fall pathway to guide staff. While I note a range of assessments had been completed, I note that:
	+ Consent had been obtained from the representative verbally however note the progress note entry was recorded on 31 May 2022 and did not reflect this had occurred on admission.
	+ Challenges in being able to complete observations, but do not have any further information to determine appropriateness of these.
* However, while note some reference to behaviour management interventions and strategies used prior to the use of the restrictive practice for Consumer B, I am persuaded by the Approved Provider’s response, that there was adequate information to demonstrate behaviour charting was consistently being undertaken, potential risks or initial information gathered had been consistently identified to guide staff in the implementation of alternative strategies (prior to the use of a chemical restraint). Furthermore, in relation to episodes of coughing, I note the consumer was on a modified diet and staff had raised concern regarding the consistency of the porridge not being appropriate. I do however acknowledge that since the visit, the consumer had been reviewed by speech pathologist and extract of progress notes did not identify any further incidents.
* With respects to behaviour support plans, I note the Approved Provider acknowledged these had not been completed and had developed a plan to complete this.
* I have also considered information and evidence in relation consumers under Standard 3 Requirement (3) (d) where the Assessment Team had identified deterioration had not been escalated in a timely manner to the medical officer. Given aspects of their care did not consistently demonstrate timely follow up, I have considered this more broadly in respects to the safe and effective provision of care and therefore have considered this information under this requirement.

Therefore, based on the information before me, I find the service Non-compliant with this requirement. While I acknowledge the improvement actions being implemented and subsequent reviews undertaken for specific consumers, at the time of the visit, the service was not able to demonstrate each consumer’s care was safe and effective that was based on best practice, tailored and optimised their wellbeing. The service will require a period of time to demonstrate its systems are consistently sustainable.

### Requirement 3(3)(b) Non-compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The service was previously found Non-compliant in this requirement as the service did not manage the risks related to one consumer’s changing needs in line with their care plan.

However, during this visit, the Assessment Team found the service was not able to demonstrate there was effective management of high impact or high prevalence risks for each consumer in relation to risks associated with choking and aspiration, prevention and management of pressure injuries, wound care and the administration of medications via PEG (Percutaneous Endoscopic Gastrostomy). Information and evidence gathered by the Assessment Team relevant to my findings included:

* For Consumer E the service did not manage risks associated with choking and aspiration effectively. Although assessments were completed, and staff were aware of the choking and aspiration risks and strategies to be implemented, the consumer’s safety was compromised at times when they were not supervised with food and fluid intake.
	+ Five incident reports from 1 August 2021 to 3 June 2022 noted there were two occasions where documentation indicates the consumer had a choking episode when eating foods as staff were not closely supervising the consumer for all oral intake as stated in care documentation.
	+ PEG feed equipment was not always available for staff use and staff resorted to the bolus method.
	+ Risks associated with safe administration of medication via a PEG was not effectively managed and staff did not always administer the medication as prescribed.
* For Consumer F who had passed away during the audit, the consumer’s wound was not identified until the wound was at Stage 3 on the consumer’s right foot. The Assessment Team noted conflicting information about the wound and noted it was reported to deteriorate, showed signs of neurotic tissue and required amputation following an external review. Furthermore, pain severity was not escalated and reported to medical officer with increased administration of pain relief medications requested. The representative raised concerns with the management and condition of the consumer’s wound.
* For Consumer G, the Assessment Team identified the service had failed to effectively identify and manage their pressure injuries. The consumer was identified as a moderate risk of pressure injuries and had sustained two pressure injuries (one on each foot) in March 2022 as a stage 2. Within two to six days both wounds had deteriorated to either a stage 4 or stage 3 and documentation of the wound was not consistently provided. Furthermore, the Assessment noted:
	+ The second pressure injury was classified a stage 3 at the time of the visit and although medical officer reviews had occurred, wound records did not demonstrated dressings were attended as prescribed.
	+ Directives for elevating the consumer’s legs and provision of pressure area care reported by staff were inconsistent with care documentation and staff said other strategies such as an air mattress or pressure relieving booties were not in place.

The Approved Provider response refuted aspects of the Assessment Team’s findings and provided supplementary/clarifying information about each of the named consumers. It also provided a plan for continuous improvement outlining actions being undertaken by the service to address the deficiencies. The Approved Provider asserted there was no risk to harm for consumers but agreed with the Assessment Team’s recommendation and had commenced remedial measures to address these deficiencies in documentation.

* In relation to Consumer E, the service outlined the consumer’s cognitive capacity to make decisions and outlined the consultation and discussion regarding risk mitigation strategies to support their choice.
	+ It considered staff were appropriately trained and consultation with the speech pathologies had occurred to explain the risks and safe strategies.
	+ Staff were to supervise the consumer and the consumer was to consume meals in the common dining area or to alert staff if eating elsewhere.
	+ Consumer on several occasions had chosen not to adhere to the recommendation of the care plan and staff advice. Since the audit, the service had continued to work with the consumer to develop strategies to support safe swallowing.
* In relation to Consumer F, the Approved Provider outlined the consumer had complex medical diagnosis that impacted on wound healing and considered the Assessment Team’s report had demonstrated the involvement of staff in managing their chronic and complex wounds. It considered records demonstrated ongoing monitoring and management of pain, attendance to the consumer’s wound and consultation with both the representative and medical officer. It did however, acknowledged gaps in documentation and agreed that documentation surroundings wounds could have been improved. As a result, the service’s plan for continuous improvement included a range of improvements relating to staff training and the use of an electronic wound assessment tool to ensure more comprehensive documentation.
* In relation to Consumer G, the Approved Provider provided clarifying information about the consumer’s complex medical condition and outlined the consumer was mobile but had poor exercise tolerance and care plan directions that were in place regarding pressure relieving strategies including positioning and support to do so. It acknowledged medical officer involvement and consultation and reported pressure injuries have since healed. Furthermore, it agreed improvements in documentation could be made, however reinforced there were other instances of effective management of high prevalence/high impact risks.

In coming to a view about compliance, I acknowledge the service has agreed with aspects of the Assessment Team’s information and commenced addressing delicences through it plan for continuous improvement. While I have considered additional information submitted, I am not persuaded by the Approved Provider’s response that consumers’ high impact/high prevalence risks were effectively managed.

* For Consumer E incidents did not consistently demonstrate staff were following care plan directives to support the consumer’s dignity of risk. However, in relation to the medication incident and no stock of specialised equipment, I note whilst these were deviation in care; they appeared to be isolated incidents and had been followed up by the service. With respects to care staff competency delivering medications via PEG tube, I note there were no incidents or impact on care, I have considered this further in relation to Standard 7.
* For Consumer F, I am not persuaded by the Approved Provider’s response, as it had not adequately demonstrated there had been an escalation of pain nor provided further evidence surrounding the management of the consumer’s complex wound in response to an external party reporting it to be neurotic and requiring significant surgical intervention. It did however acknowledge improvements in its documentation of these matter and included this as part of its overall plan for continuous improvement.
* For Consumer G, I accept that care plan interventions were in place to prevent /minimise the risk of pressure injuries, medical officer reviews and underlying conditions potentially impacting on wound healing. Whilst extracts of the consumer’s care plan and staff confirm strategies in place for repositioning and reducing pressure to heels; I am concerned the pressure injuries acquired were not identified until they were a staged two; within six days both had deteriorated to either a stage 3 or 4. Furthermore, wound directives were not recorded as consistently followed and at the time the pressure injury was reported to be a stage 3.

Therefore, based on the information before me, I find the service Non-compliant with this Requirement as the service was not able to demonstrate specific risks for consumers were being effectively managed. Although improvements are being made, the service will require a period of time to fully implement and determine the effectiveness of its systems.

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Compliant

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

The Assessment Team recommended the service as Not met as it was unable to demonstrate deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition was recognised and responded to in a timely manner. The Assessment Team noted examples in progress notes of two consumers which indicated when changes to their condition was recognised and documented in their progress notes, however, clinical staff did not escalate changes to their Medical Officer in a timely manner. For example:

* A consumer who was prescribed eye drops which could lower his blood pressure, the blood pressure level did fall however, the medical officer was not notified of the blood pressure reading. Subsequent follow up by the medical officer in January 2022 resulted in medication being provided to increase blood pressure and staff to monitor. The consumer blood pressure reading in January 2022 showed lowered readings and observed changes in the consumer such as pain, changes in oxygen saturation levels and elevated temperature. The Assessment Team noted there was limited evidence to demonstrate the medical officer had been notified, until third day when the consumer was sent to hospital and was prescribed antibiotics for an infection.
* The second consumer with a significant fracture and who refused their prescribed pain relief medication due to concerns with heart burn/reflux and difficult sleeping at night. The medical officer was not notified for consideration for an alternative pain medication in a timely manner.

The Approved Provider refuted some of the evidence reported and its response reinforced there was no risk of harm to their consumers. It did however report the service need to ensure that comprehensive documentation was maintained that reflected all personal and clinical care as well as consultation with external health professionals. As a result, it had implemented remedial actions following the site audit to address this. In relation to the two consumers it had reported:

* In relation to the first consumer, the service reported the consumer’s reportable ranges were lower than other consumers and considered other underlying factors including the consumer’s willingness to mobilise could have contributed to falls as opposed to the eye drop medications.
* For the second consumer, it refuted the Assessment Team’s information reporting there was appropriate consultation that had occurred between the consumer and medical officer regarding the management of their longstanding chronic pain and considered clinical records supported these consultations occurred at appropriate frequency.

In coming to a view about compliance, I have considered both the Assessment Team’s report and the Approved Provider’s response. Although I have come to a different view to that of the Assessment Team and find the service Compliant in this requirement, I have considered these deficiencies in relation Standard 3 Requirement 3 (a).

While I acknowledge the service are implementing improvements in relation to its clinical documentation, I am not persuaded by the Approved Provider’s response that action was taken in a timely manner to notify the medical officer the consumer’s blood pressure readings (during a period where these were outside of the parameters reported). Furthermore, there were other changes in the consumer that were indicating a deterioration or change and was limited evidence to demonstrate timely escalation of these.

For the second consumer, during May 2022, the consumer had refused regular and PRN strong pain relief medication due to heartburn/reflux experienced. I note the medical officer had reviewed the consumer early May 2022 regarding declining of pain medication, and further incidents of refusals had occurred.

Although I accept the medical officer was reviewing and discussing the refusal of medications, I am not persuaded that the reason for refusal was communicated to support further consideration and noted the regular dose was continued and PRN ceased. Furthermore, whilst the consumer reported they experienced in a lot of pain upon movement, I do not have sufficient evidence to come to a view that during the period of refusal, the consumer’s pain was not being effectively managed. I do note however, subsequent reviews by the medical officer indicated the pain was managed and at the time of the site audit the consumer did not indicate they were significant pain.

In coming to a view about compliance, I have also considered the totality of other information within the Assessment Team’s report and note that:

* Consumers sampled stated they had access to medical officers and other relevant health professionals when they need it.
* Consumers and representatives sampled were generally confident staff providing care and services would identify changes to consumers’ health and well-being and will refer them to other allied professions when necessary.
* Staff were knowledgeable about how referrals were completed and how the service communicated any changes or recommendations to staff, consumers and representatives.
* the service was able to demonstrate other examples of timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* Effective processes were in place for providing and caring for palliating consumers.

Therefore, based on the information before me I find the service Compliant in this requirement.

### Requirement 3(3)(e) Compliant

*Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

Overall sampled consumers considered they received the services and supports for daily living that were important for their health and well-being and enabled them to do the things they want to do. Feedback included:

* Overall consumers and representatives were happy with the quality, quantity, and variety of meals, were able to provide feedback and they could access alternate food if their meal was not to their liking.
* Consumers said staff were supportive of their emotional, spiritual and psychological well-being.
* Most consumers and representatives said the service supports them to participate in their community and do the things that interest them.
* Consumers said their condition, needs and preferences had been identified by the service and were known by staff, including their religious affiliations, personal/family relationships and emotional needs.
* Consumers said there was enough equipment such as lounge chairs, tables and chairs for them to use, and personal equipment or equipment provided by the service, was well maintained.

The service was generally able to demonstrate how they supported consumers to participate in their community, have social and personal relationships and do things of interest to them. Staff said information pertaining to the consumer’s condition, needs and preferences was documented in the care plan, which was accessible to all staff via the electronic system, communicated through handover and information was also located in the consumer’s rooms. Staff were able to provide examples of how they assisted and supported consumers to do the things they liked and to participate in the community; lifestyle staff described how they worked with external organisations and accessed volunteers to supplement their lifestyle activity program. During the Site Audit the Assessment Team observed consumers participating in group activities, visitors in attendance and consumers engaging with each other in communal spaces.

Care planning documentation generally showed information about what and who was important to consumers, including information about their background, life story, past and current interests, religious and other cultural practices. The Assessment Team noted most consumers had individualised goals and received support as stated in their lifestyle care plan or were provided activities on a regular basis. Staff were generally able to describe how consumers who were identified as requiring further support, such as wellbeing or mental health supports were assisted.

However, not all lifestyle assessment reviews had been completed in line with the service’s policy of 6 months; some care plans did not always reflect the individual goals of consumers and further assessments were not always considered following an incident. Given the nature of these deficiencies related to the service’s assessment and review processes, I consider this information more relevant in relation to Standard 2 Requirement 3 (e) including Standard 8 along with the Approved Provider’s response.

The service demonstrated where meals were provided, they were varied and of suitable quality and quantity. The service had rotating menu which has been reviewed and by a dietitian. Care plan documents included a nutrition and hydration assessment and plan, identifying dietary requirements, including food sensitivities, food texture requirements and assistance required for meals. Staff demonstrated knowledge of consumers’ requirements and there were processes to monitor consumer satisfaction with meals.

The service was able to demonstrate equipment provided inside and outside the service was comfortable, clean and well maintained. Processes were overall effective in sourcing and assessing equipment suitable for consumers.

The Quality Standard is assessed as Compliant as seven of the seven specific requirements have been assessed as Compliant.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANTOrganisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

Overall sampled consumers felt they belonged at the service and felt safe and comfortable in the environment. Feedback included:

* The service was welcoming, consumers could access all areas and enjoyed using the communal areas.
* Consumers were happy with the standard of cleanliness and felt safe in their environment.

The Assessment Team observed:

* The service environment was welcoming and well maintained, enabling consumers to generally move freely both indoors and outdoors throughout the service. Consumers were provided with swipe cards to access areas of the service. For those consumers who were not able to be provided with a swipe card, the service outlined there was a risk assessment and consent process in place for restricting a consumer’s access.
* Multiple outdoor areas were available for consumer use and consumers utilising walking paths and enjoying the surrounding gardens. Consumers were observed utilising the amenities available to them by sitting in activity and outdoor areas interacting with one another, gardening and reading.
* Garden areas and pathways were overall observed to be well maintained and free of any hazards.
* The dining room was large, well-furnished and decorated based on consumer suggestions.
* Corridors were clean and not obstructed by equipment, handrails were in place and ramps for consumers to mobilise easily around the facility environment.
* Consumer rooms were personalised to their taste and choice, clean and well maintained.

Management described how they ensured the service environment, equipment and consumers’ rooms were safe, cleaned and maintained. The service also ensured improvements to the service were held in consultation with consumers.

The service was able to demonstrate furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. Maintenance records demonstrated regular maintenance of the building and equipment and maintenance issues were actioned in a timely manner, including the use of contractors when required. Both cleaning and maintenance staff described how the service’s environment, equipment and consumers’ rooms were cleaned and maintained.

The Quality Standard is assessed as Compliant as three of the three specific requirements have been assessed as Compliant.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 COMPLIANTFeedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

Overall sampled consumers considered they were encouraged and supported to give feedback and make complaints, and appropriate action was taken. Feedback included:

* Consumers and representatives were aware of the different methods to raise complaints. Consumers said feedback was primarily given verbally or at resident meetings and were satisfied with the process.
* Consumers and representatives said they felt supported to provide feedback and make complaints.
* Consumers were satisfied with the way in which management managed and responded to complaints and feedback and said they felt feedback was actioned promptly and improvements were identified and implemented.

Staff were able to describe how they supported consumers and representatives to provide feedback. Staff described how they raise issues or concerns on behalf of consumers and were aware of language and advocacy services.

Staff said they do not have any consumers that require language services, however there were cue cards and information in other languages available if required. Most staff were aware of the term open disclosure and the importance of resolving issues and apologising to consumers when things went wrong.

Information about providing feedback, both internally and externally, was provided to consumers in the resident handbook, as well as posters and pamphlets located throughout the facility also highlighting this information. The service had also recently implemented a quality newsletter providing information about care and services in relation to the Quality Standards which includes information on how consumers can make a complaint both internally and externally.

The service has a complaints framework and policy which contains the process for managing complaints. The organisation had an open disclosure policy and processes in place to ensure staff and management apply open disclosure practices when things go wrong. The Assessment Team viewed complaints raised by consumers and representatives which showed the service recorded feedback, both written and verbal, and responded appropriately.

Management said most consumers were comfortable talking directly with staff and primarily give verbal feedback. Any issues are followed up by management and if related to care and services they would contact the consumer and/or their representative to explain what has happened and offer a formal apology. Complaints were regularly analysed by management and reported at consumer, staff and management meetings where appropriate.

Management was able to describe how the service monitored complaints through the complaints register and how this contributed to improvements of the environment and to the delivery care and services for consumers.

The service had a staff complaints, suggestions and compliments register where staff have provided feedback regarding improvements to care and services, and the service environment.

The Quality Standard is assessed as Compliant as four of the four specific requirements have been assessed as Compliant.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

Most sampled consumers and representatives considered they received quality care and services when they needed them and from people who were knowledgeable, capable and caring. For example:

* Consumers and representatives said there was enough staff to meet consumers’ personal care needs in a timely manner and reported staff attended to call bells promptly.
* Consumers and representatives said staff were kind, caring and respectful.
* Consumers sampled said they considered staff knew what they were doing, were able to meet consumers’ care and service needs, and did not express any training areas that required improvement. However, some representatives raised concern regarding the knowledge and skill of staff to provide quality of care and services to the consumer.

The service was able to generally demonstrate staffing levels were sufficient and management outlined this was regularly monitored based on the occupancy rate and acuity of the consumers. The service’s staffing structure showed there was a Registered Nurse rostered each shift with the support of Enrolled Nurses and/or care staff. Management identified there were rare occasions where a Registered Nurse was not rostered at the service, the Clinical Manager was on call to provide assistance.

Most staff said there was generally enough staff to provide care and services to consumers in a timely manner, with most shifts filled by management where possible. The Assessment Team however did identify some gaps lifestyle documentation and reviews being completed due to reported staffing implications and roster/allocation sheets did not always demonstrate shifts were replaced. Management outlined some of the strategies employed to minimise the impact of this and following recent feedback by staff was considering trialling a new short shift.

The Assessment Team observed staff interacting with consumers in a kind, caring and respectful manner, were attending to consumers' needs in a timely way and did not appear to be rushed.

The service was able to demonstrate the workforce was generally recruited, equipped, and supported to deliver the outcomes required by these standards. The service had an initial onboarding process which involved mandatory training and buddy shifts. Following recruitment, the service provided ongoing training to staff, however, training options were not mandatory and training records indicate minimal completion. The Approved Provider’s response outlined its commitment to continuous improvement and improvements being undertaken in relation to training for staff. Staff generally felt supported to deliver safe and quality care and services to consumers.

The Assessment Team noted the staff performance framework was supported by policies and procedures such as disciplinary process, and staff performance appraisal process. The staff appraisal register showed staff appraisals were last completed within the last 12 months and appraisals included an employee self-reflection and supervisor comments.

However, the Assessment Team recommended one requirement not met as it found staff did not always have the knowledge and competency to undertake their roles and monitoring systems were not always effective in identifying areas for improvement.

The Approved Provider provided a written response in relation to above matters and based on the information before me, I find the service Non-compliant in Standard 7 Requirement 3 (c). The reasons for my decision are outlined below under the relevant requirement.

The Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Non-compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

The service was previously found Non-compliant in this Requirement as the service did not ensure clinical staff had sufficient skills and knowledge in the administration of schedule eight medication to perform in their roles safely and effectively. The Assessment Team spoke to management in relation to the plan for continuous improvement and were informed the following improvements have been implemented relating to:

* The provision of additional training in medication safety and practical drug calculation including administration of schedule eight ampoules.
* Review of the management of controlled drugs policy, further instructions provided to staff on the eight rights of medication administration and holding over of stock.
* Appropriate referral and reporting of the incident had occurred.

During this visit, the Assessment Team found the service was unable to demonstrate systems and processes to support the assessment and checking that staff have the skills, knowledge and qualifications to competently undertake their roles. Specifically the Assessment Team found that:

* Although management outlined the processes for monitoring staff competency and knowledge, the service was not able to provide examples of clinical concerns based on staff competency through these mechanisms.
* Whilst there was a consideration of training for staff, this was limited and did not consistently support the upskilling of staff or ensured staff competence. The Assessment Team noted, a review of training opportunities for new and existing staff had been identified on the continuous improvement plan (CIP) with consideration for more practical training opportunities.
* Two representatives did not feel staff were knowledgeable about dementia or wound management.
	+ One representative felt staff lacked the knowledge to provide care and services in relation to the management of the consumer’s wound and did not feel wounds were regularly attended to or monitored in line with wound management plans.
	+ One representative stated they felt staff were not equipped with the knowledge required to effectively manage behaviours associated with Dementia which caused an increase in behavioural related physical incidents.

In relation to wound management

Clinical documentation for two consumers identified wounds were not always regularly photographed, reviewed or staged correctly in line with the wound management plan. Specific concerns in the management of consumers’ wounds has been further explored in relation to Non-compliant requirements in Standard 3.

Training records showed wound training was available for staff online, however, it was not mandatory, and records showed training not been undertaken by staff. Furthermore, staff who were currently appointed to undertake wound care did not advise of any additional wound management education or indicate any ongoing training.

In relation to behaviour management/restrictive practices

Although five care staff confirmed they have received some training on restrictive practices; however, they were not aware of the requirements or purpose of behaviour support plans. The Assessment Team noted deficiencies in the management of restrictive practices including alternative strategies were not always used prior to administering chemical restraints (as outlined in Standard 3 and 8) and staff were not always knowledgeable of the requirements for risk discussion associated with the use of bed poles/rails.

Two carers said some staff were better equipped to deal with consumers who have severe dementia, whilst others lack patience for managing consumer behaviours. Staff said they use personal experience to manage consumers behaviours or will walk way and return later. Two of the three care staff said dementia training would be advantageous and it has been requested by staff during a recent carer meeting held during the visit.

Management had not consistently assessed the level of harm or potential level of harm for consumers following incidents and had not applied consideration of the incident for mandatory reporting purposes. However, I have considered this information in respects to Standard 8 as it is more relevant to the organisation’s governance systems.

In relation to medication management/tube management

Staff did not always have the qualifications or demonstrate their level of competency to undertake complex clinical care. The Assessment Team noted there was limited evidence to demonstrate medication competent carers were deemed competent in undertaking high risk clinical tasks information regarding medication administration for a consumer with a percutaneous endoscopic gastrostomy tube.

In relation to fire and mandatory training

The Assessment Team noted mandatory training was overdue since March 2022 for manual handling and fire safety. Whilst training was mostly delivered online, a maintenance staff member advised they provided fire induction to new staff. However,

* Maintenance staff were not certain training had been provided to all new staff based on the requests to complete training.
* Two care staff interviewed confirmed they had received fire training approximately one year ago and were not confident in all aspects of responding in the event of a fire. Furthermore, staff raised they did not confident that newer staff members would know what to do.

The Approved Provider refuted the Assessment Team’s findings and considered its workforce was competent and had the required qualification and knowledge to effectively perform their roles as evidenced throughout the report. Its response included additional evidence of medication competencies, the service’s training calendar/schedule and a plan for continuous improvement which outlined specific training and improvements to being undertaken. Furthermore, it reported:

* There were multiple mandatory training topics currently in place for staff which included testing competency and skills of staff relating to emergency, medications, manual handling and trauma. In addition, it also identified the following compulsory training was to commence in 2022 - infection control/hand hygiene, wound management, elder abuse/SIRS, restrictive practices/behaviour support plans, COVID, medication calculations and dementia training.
* The service also offered a suite of online training which was not compulsory for nursing staff to complete but was to support their professional development and knowledge.
* In respects to behaviour management/restrictive practices – it acknowledged the feedback from staff and representatives and compulsory behaviour support plans and dementia training would be organised. In relation to bed poles and rails for named consumers, its response had been already detailed in relation to Standard 2 and 3.
* In relation to PEG training – medication credential carers were trained and competent to perform crushing of mediation and flushing of PEG pre and post medication. It provided evidence of two staff members’ competency assessments and reported the medication incident had been an isolated incident and reinsertion of a PEG was in line with the service’s process.
* Compulsory wound management training had been organised for 8 July 2022 and training would be held by a wound specialist company and further improvements to its wound management processes would be implemented.
* In relation to incident management/SIRs the service had streamlined its systems and knowledge of its reporting and incident management obligations. It outlined it had reported a number of SIRs incidents and did not consider those identified by the Assessment Team consistently required reporting.
* Compulsory medication training would be completed annually with the pharmacy for staff as part of its contract.

In coming to a view about compliance, I have considered the Assessment Team report and the Approved Provider’s response. While I acknowledge the service’s actions being undertaken, current training in place and further information submitted on medication competencies for staff, I am not satisfied the service’s processes had implemented effective processes in ensuring staff were consistently knowledgeable and competent in undertaking their roles.

Specifically, the Approved Provider’s response did not adequately demonstrate it had consistently had effective system to ensure staff had the required knowledge or competency relating to wound management, restrictive practices and behaviour management and note these areas had deficiencies in relation to care delivery. In addition, staff identified instances where they did not feel confident in responding to an emergency and had raised concerns about other staff ability on dementia care. While I note, the Assessment Team considered gaps in knowledge for reporting serious incident reports, I have considered the reporting of specific incident more relevant to Standard 8 Requirement 3(d).

Furthermore, I acknowledge the service had a competency tool to assess staff in relation to administration of medications via PEG and it provided evidence of this. Whilst I accept staff competency has been assessed for two staff, I note that tube management as outlined under the Quality of Care Principles defines relevant qualifications of staff to perform specific clinical care tasks. Although I do not have any further information on whether this had been considered as part of the service’s decision-making process, (for determining suitability of staff performing tube related tasks), I note the Assessment Team had not identified any incidents relating to care staff performing this practice.

Therefore, based on the information before me, I find the service Non-compliant in this requirement. At the time of the site audit, the service was not able to consistently demonstrate an effective system for assessing staff knowledge or competency in respects to clinical requirements and other mandatory training such as fire. While I acknowledge a range of improvement actions and additional education has been planned, the service will require a period of time to demonstrate the effectiveness of its systems.

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

Overall sampled consumers considered that the organisation was well run and that they could partner in improving the delivery of care and services.

Management described and provided evidence of how consumers had input about their experience and the quality of care and services through care plan reviews, meetings, feedback and surveys.

The organisation had a range of reporting mechanisms to ensure the Board and leadership team was aware and accountable for the delivery of care and services.

The organisation was able to generally demonstrate an established, documented and effective organisation-wide governance systems in relation to information management, continuous improvement, financial and workforce governance, feedback and complaints. Whilst the service was not able to consistently demonstrate regulatory compliance systems were consistently effective in meeting regulatory requirements with regard to restrictive practice legislation and incident reporting under SIRS, I have considered this information in respects to the service’s broader system for identifying and ensuring compliance. I therefore find this information more relevant in relation to risk management and clinical governance systems for minimising restraint.

In relation to other requirements, the Assessment Team noted that:

* The service was unable to demonstrate their risk management systems were effective in managing high impact or high prevalence risks for all consumers, including reporting and preventing incidents, supporting consumers to live their best life and identifying neglect of consumers.
* The service was unable it clinical governance system relating to the minimisation of restraint had been consistently implemented.

The Assessment Team recommended three requirements Not met in relation to this Standard. The Approved Provider provided a written response along with a plan for continuous improvement.

Based on review of this information, I have come to a different view to that of the Assessment Team and find Standard 8 Requirement 3 (c) Compliant and Standard 8 Requirement 3(d) and 3(e) Non-complaint. The reasons for my decision are outlined below under the relevant requirements.

The Quality Standard is assessed as Non-compliant as two of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### Requirement 8(3)(c) Compliant

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

While the organisation was overall able to demonstrate effective governance systems in relation to information management, continuous improvement, financial governance, workforce governance and feedback and complaints, the Assessment Team found the organisation was unable to demonstrate an effective organisation-wide governance system in relation to regulatory compliance with regard to restrictive practice legislation and incident reporting under SIRS. Specifically, the Assessment Team noted that whilst the organisation was aware of legislative changes, it had not ensured compliance with the Quality of Care Principles in implementing behaviour management support plans for those consumers were a restrictive practice was in place and the consistent reporting and categorising of serious incident reports. Information gathered by the Assessment Team included:

* The organisation maintained a regulatory compliance register which outlined updates, information sources, departments affected and details for how information was distributed to necessary parties. However,
	+ The Assessment Team noted the service’s policy was not reflective of restrictive practice requirements and it had developed an action plan to address the completion of behaviour support plans in which 16 out 21 were outstanding at the time of the visit.
	+ Incidents had not been consistently reported or categorised including five incidents for consumer that had not been reported, following incidents of choking that were not supervised by staff as outlined in care needs and one incident of inappropriate behaviour involving a female consumer. Management stated they had not considered these incidents to meet the threshold for reporting under SIRS, however, would review the incidents for consideration.

The Approved Provider refuted the Assessment Team’s findings and reported it did have effective governance systems in place. Its written response included a plan for continuous improvement as well as supplementary documentation such as policies/procedures and education. Its response provided clarifying information about the definitions contained within the service’s restrictive practice policy on mechanical and physical restraint which was reported to be updated during the visit to reflect the reference to behavioural support plans.

The Approved Provider reinforced the service was aware of the requirement for this and the Board had approved the engagement of an external organisation to support compliance with restrictive practice legislation which an action plan to address compliance with this legislation. Furthermore, it had advised the training calendar has been adjusted and included mandatory behaviour support plan training for staff to ensure they are equipped with the knowledge to effectively manage consumers with behaviours and restrictive practices.

In relation to serious incident reporting, management advised they would review the four incidents relating supervision of meals for the above consumer and had sent out information to staff reminding them of their responsibilities. Furthermore, it had advised an additional discussion had occurred with consumer reminding them of their responsibilities to follow safe swallowing strategies. In respects to the last incident, it did not consider the incident required reporting under SIRs.

In relation to other sub-requirements I noted the Assessment Team had identified gaps in relation to workforce governance relating to Standard 7 Requirement 3 (d) and the service’s continuous improvement specifically relating to incidents had not always been assessed to identify areas of improvement and delays in improvements being actioned and evaluated. However, I have in this is the broader context of those requirements in Standard 7 Requirement 3 (c) and Standard 8 Requirement 3 (d).

In coming making a decision about compliance, I have considered the Assessment Team’s findings and the Approved Provider’s response and have come to a different view and find the organisation Compliant in this requirement. This is based on the following:

* The organisation was overall able to demonstrate effective governance systems in information management, continuous improvement, workforce governance, feedback and compliance and financial governance.
* The organisation was able to demonstrate it had a system to identify changes in respects to regulatory compliance.
* It had identified behaviour support plans were required and had developed an action plan to address this. I also note the service had employed a Quality and Compliance Officer who would be assisting in supporting the service. I am concerned however, the requirements for behaviour support plans come into effect in September 2021 and the service was yet to demonstrate this was fully implemented for all relevant consumers. Since the visit, I note the Approved Provider reported additional behaviour management plans had been implemented and training would be undertaken for staff. Given the additional gaps in restrictive practices identified under Standard 3, I am of the view that whilst the service had a plan to address compliance and was able to demonstrate some plans had been completed, it was not able to demonstrate its clinical governance system was fully implemented to minimise the use of restraint.
* In relation to the specific incidents identified by Assessment Team for a consumer; I am concerned that whilst the organisation advised it would subsequently review these, the service’s processes should consistently ensure incidents were consistently reviewed to ensure its obligations are met. I do however note other examples where the service had reported incidents under SIRs legislation and find the concerns raised by the Assessment Team extended beyond meeting legislative requirements and related to ongoing safety and management of risks. I have therefore considered this in respects to risk management.

Whilst I acknowledge the organisation was not able to consistently demonstrate regulatory compliance had been met on each occasion, I am of the view that changes in legislation were being identified; although not consistently timely, action plans were developed to address compliance issues and other examples showed the organisation had met its obligations. In addition, the service had implemented a plan for continuous improvement to assist in addressing its governance systems.

As I have considered these deficiencies in relation to other governance requirements and the organisation still has ongoing obligations to ensure its systems continue to be effective.

### Requirement 8(3)(d) Non-compliant

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

The service was previously found Non-compliant in this requirement as the service did not adequately prevent and manage incidents, including through the implementation and use of an electronic incident management system.

The Assessment Team spoke to management in relation to the plan for continuous improvement and were informed the following improvements have been implemented:

* Training for SIRS Committee on investigation and incident reporting.
* Incident Management System policy and procedure reviewed and updated.
* Recruitment of a Quality Manager to manage quality improvements.
* Compulsory training for all staff and board members on SIRS.
* SIRS policy created in line with the Quality Care Principles and a policy communicated to staff, consumers and representatives.

However, during the site audit, the service was unable to demonstrate effective risk management systems and practices were in place for the management of high impact or high prevalence risks, reporting and preventing incidents, supporting consumers to live their best life and identify neglect of consumers. Information and evidence gathered by the Assessment Team relevant to my findings included:

* While the organisation has documented risk management framework, including policies describing how risk were managed, the service had not consistently identified all relevant risks and where mitigating strategies had been implemented, these were not always followed by staff. Specifically, the Assessment Team noted:
	+ The service's risk management systems and processes were not effective in managing and supporting one consumer who chooses to eat meals outside of their assessed needs. Whilst the service has identified mitigating strategies, incident reports reviewed (between August 2021 and May 2022) showed those strategies were not always implemented including staff supervision and food cut up into smaller bite size pieces. Furthermore, the service had not consistently considered whether incidents were reportable under SIRs.
	+ The service had implemented a barrier preventing a consumer from leaving their room without staff assistance during a period of COVID restrictions in May 2022. Although removed prior to the site audit, the risk to the consumer had not been considered from a wellbeing or fire related perspective.
	+ The Assessment Team found two consumers had bed poles and one consumer had bilateral bed rails, the service had not completed a dignity of risk form with consent from the consumer or representative. Staff interviewed were not aware the use of bed rails, bed poles and concave mattresses required a dignity of risk form and discussion with the consumer and/or representative to discuss risks associated with their use.
	+ SIRS reports raised from 1 January to 31 May 2022 showed:
		- Of the 10 incidents reported, seven incidents of physical abuse involved two consumers in which the Assessment Team reported neither consumer had a behaviour support plan with strategies for managing and preventing incidents of physical abuse.
		- Further incidents of 'unreasonable use of force’ (total of five) did not demonstrate the service had considered the ongoing risk to their emotional wellbeing following an initial emotional response due to the consumers being diagnosed with dementia.
* I have also considered the totality of evidence in relation to clinical care deficiencies and the effectiveness of the service’s processes to identified specific clinical risk. Of note, the service was not able to consistently demonstrate high impact and high prevalent risks for two consumers with wounds/pressure injuries had not been effectively managed.

The Approved Provider’s response disagreed with the Assessment Team’s findings and provided a response which outlined actions already outlined in previous requirements as well as submitted a plan for continuous improvement outlining action being undertaken to address the identified deficiencies. Its response specifically addressed the SIRS incidents would be revisited and not all were required to be reported.

* For one where the barrier had been used for the consumer, it had advised the reporting requirements for P2 had been met.
* In relation to the consumers with physical behaviours and assessment of wellbeing risks, I have already considered the approved Provider’s response previously detailed. It had further advised for one consumer the service was continuing to manage their ongoing behaviours and reporting of SIRs incidents. Specifically, it outlined the specific behavioural interventions being used including listing involvement of other specialist services.
* In relation to wound management, I have considered the Approved Provider’s response in relation to the name consumers and improvements to its electronic system for wound management.
* In respects to staff provision supervision for the consumer and the choking incidents, I have considered the Approved Provider’s response detailed throughout the report and the subsequent reporting of further discussion of safe swallowing strategies.
* In relation to the use of bed rails and concave mattresses its response reported these were covered under restrictive practices, risk assessments and consent forms were in place. Although it provided an example for one consumer, its response did not demonstrate these were completed for the remaining two consumers with bed poles, however had since reported these were being removed.

While I acknowledge the service had undertaken further actions and developed a plan for continuous improvement to support improvements in its systems, I am not persuaded by the Approved Provider’s response that the service had consistently implemented effective risk management systems and practices in respects to consumers and the overall management of clinical risks. Incidents or variances in did not consistently lead to improvements in care and services. Therefore, based on the information before me I find the service Non-compliant in this requirement. I note the service will require a period of time to fully implement and evaluate the effectiveness of its risk management systems.

### Requirement 8(3)(e) Non-compliant

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

The Assessment Team found the organisation had not fully implemented an effective clinical governance framework relating to the minimisation of restraint. Specifically, the Assessment Team noted:

* The service did not have up to date policies and procedures to guide staff in understanding and minimising the use of restraint. The organisation’s restrictive practice policy dated September 2021 did not include information regarding the requirement for BSP’s or the requirement for alternate strategies to be used prior to administering restrictive practices.
* The service was not able to demonstrate restrictive practices were used as a last resort. Staff interviewed confirmed the requirement to attempt alternate strategies prior to administering chemical restraints, however staff have not always used alternate strategies before administering chemical restraint. In addition, behavioural support plans for those consumers identified as being on a restrictive practice had not been fully implemented.
	+ The Assessment Team found the service has not completed BSPs for 16 of 21 consumers who are subject to restrictive practices and as evidenced under Standard 3, Requirement (3)(a).
	+ The Assessment Team identified for one consumer, the service was not able to demonstrate staff had always considered alternative strategies prior to the administration of chemical restraint medications.
* Care staff interviewed confirmed they are aware of restrictive practice definitions; however, they were not aware of BSPs or the purpose of a BSP. Staff said they had never seen a BSP and did not believe consumers had them outlining strategies to use prior to administering chemical restraints.
* The service was not able to demonstrate consent had not consistently sought prior to the implementation of restraint for the use of a barrier and chemical restraint. The Assessment Team noted an example where inappropriate use of a restrictive practice was used without consent in May 2022, preventing the consumer from leaving the room without staff assistance during an outbreak. Furthermore the service was not able to demonstrate records of timely consent for a consumer who had been prescribed chemical restraint, prior to entry to the service.
* Management did not trend or audit restrictive practice data to identify ways to minimise the use of restraint.
	+ Management said restrictive practices are an area of focus for the organisation, specifically regarding the completion of BSP’s and auditing and trending tools to identify minimisation opportunities for consumers subject to restrictive practices. Management stated this is not currently occurring. The service has engaged an external contractor to undertake BSP’s for consumers which has been approved at Board level. This has been delayed due to COVID-19 outbreaks and is scheduled to commence on 6 June 2022.
* Management stated staff have been trained on restrictive practices through ‘Quality Standards’ training undertaken by staff last year to ensure understanding of types of restrictive practices and ways to minimise the use of restraints. Management stated there was additional restrictive practice training available to staff, which is captured on the annual training schedule, however, this training was not mandatory. The Assessment Team viewed the training logs and nil staff had been recorded as having completed the online training.

The Approved Provider provided a response which included evidence of its policy, extracts of clinical documentation, training schedules as well as a copy of its plan for continuous improvement.

* The Approved Provider outlined the psychotropic register was regularly reviewed which included reviewing PRN medication use and referring to the medical officer as required. However, it did not evidence how this was being used to support further reviews.
* The Board had approved the engagement of an organisation to support the service to be compliant with restrictive practices legislation.
* The Restrictive Practice policy had been updated during the site audit to reflect changes to behaviour support plans and the policy would be distributed to staff for their understanding.
* Training to calendar had been adjusted to include mandatory behaviour support planning training.
* The service outlined generalised strategies being undertaken in relation to supporting consumers with changed behaviours which includes referral and involvement of medical officer and completion of wellbeing checks.
* It outlined a planned process of quarterly chemical restraint reviews would include a review of PRN usage increases or decisions would trigger further medical/mediation review or to a dementia support service. It also outlined quarterly board reports to include summary of consumers using restrictive practices.
* All consumers with a restrictive practice to have appropriate assessment and plans in place.

In coming to a view about compliance I have considered the Assessment Team’s report and the Approved Provider’s response. I acknowledge the improvement actions being undertaken by the service in relation to the implementation of behaviour support plans, training for staff and the alignment of its practices with restrictive practice requirements. However, I am not satisfied the service had implemented an effective clinical governance framework in order to demonstrate the use of a restrictive practice was being consistently implemented to minimise its use. The Assessment Team noted examples where its use was not authorised, alternative strategies had not been consistently trialled or documented. Therefore, based on the information before me, I find the service Non-compliant in this Requirement. While some improvement actions have been demonstrated since the audit, the service will require a period of time to demonstrate all aspects have been fully implemented and evaluated for their effectiveness.

### Areas for improvement

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

**Standard 2 Requirement 3 (e)**

* The service to ensure there are consistently effective processes to support the regular review of care and services including following incidents or changes in a consumer.
* Ensure staff are consistently supported through resourcing to complete reviews as scheduled and strategies are evaluated for their effectiveness

**Standard 3 Requirement 3 (a)**

* Ensure the delivery of safe and effective care that is based on best practice, needs and optimises wellbeing for the consumer.
* Ensure there are effective systems for notifying medical and other health professionals in response to potential changes

**Standard 3 Requirement 3 (b)**

* Ensure there are effective management of high impact high prevalence risks associated with the care of each consumer, specifically in relation to wound and pressure area care and consumers with complex care needs.

**Standard 7 Requirement 3 (c)**

* Ensure an effective system is implemented to support the service in demonstrating its staff are consistently knowledgeable and competent the delivery of care and service.

**Standard 8 Requirement 3 (d)**

* Ensure the service consistently implement effective risk management systems to in response to incidents, clinical risks and use of equipment.
* Ensure staff are knowledgeable of the service’s requirements and there is effective monitoring and identification of risks to support improvements in care.

**Standard 8 Requirement 3 (e)**

* Ensure the organisation has an effective clinical governance system that is based on legislative requirements, its policies and procedures are reflective of these requirements and is fully implemented by the service.
* Ensure there are effective processes for assessing, planning and monitoring the use of restrictive practices